Facilitators Views on Victim Empathy work in Sex Offender Treatment and its Impact on Therapeutic Alliance

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Abstract

Participants on sex offender treatment programmes (SOTPs) seem to value victim empathy (VE) training exercises, despite there being little evidence to suggest that these reduce risk of reoffending. Participants also appear to value their therapeutic relationships. There has been very little research into SOTP facilitators' views on treatment. This study explores whether facilitators also feel VE training is a useful part of treatment and if seeing empathy develop in offenders strengthens therapeutic alliance. 12 prison SOTP facilitators were interviewed. The transcripts were analysed using content and thematic analysis, there were six main findings. Facilitators were concerned that the perceived impact of VE was superficial compliance and the particular emotional aspect of VE training may help facilitators to empathise with difficult group members. This study contributes a facilitator perspective to the debate on including VE training in SOTPs, and suggests further research be completed into empathy constructs and how these apply to facilitators work.

Keywords: victim empathy, sex offender, therapeutic alliance, qualitative

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The consequences of sexual offending for victims can include significant psychological distress, physical pain and social withdrawal (Webster, Bowers, Mann & Marshall, 2005). These factors can also impact people who are close to the victim as well as friends and families of offenders (Browne & Finkelhor, 1986). Alongside these primary and secondary effects are the social and economic costs involved in detection, conviction, and treatment for both the victim and offender. These problems are exacerbated by low detection and conviction rates (Barbaree & Marshall, 1988; Langevin et al., 1985). This means the window of opportunity for influencing the future behaviour of individuals committing sexual offences and offsetting the associated consequences is slight.

Psychotherapy has emerged as a particular method of treating sex offenders in an effort to reduce their risk of reoffending alongside behavioural and pharmacological interventions. Group based cognitive behavioural approaches are amongst the most widely delivered (Hanson et al., 2002) and usually contain a wide range of different components centred on reducing the risk of reoffending. Victim empathy has been identified as being a key target in 80% of cognitive-behaviourally based SOTPs (McGrath et al., 2009).

Empathising is the process of understanding and replicating the affect of others in order to act pro-socially towards them. It has been theorised that increasing sex offenders' ability to empathise with the victim is a protective factor against future offending. There are a number of theories of empathy that have been posited, which could explain how this process works. Davis (1994) has suggested that there are four components to empathy: antecedents, process, an interpersonal component and an intrapersonal component. It is important to note that Davis' model does not overtly state that there is a requirement for an affective component in empathising, which is a serious flaw in the model. Davis only appears to have focussed on the cognitive

component of empathising, which has been hypothesised to be a higher order function (Hoffman, 2000; Hodges & Wergner, 1997).

Marshall, Hudson, Jones and Fernandez (1995) based a different model of empathy on the supposition that empathic understanding is based on early experiences with care givers**.** They suggest a four stage model of empathy that involves recognition of emotion, adopting the perspective of the target, replicating the emotional state of the target to appreciate their affective state and then responding. Baron-Cohen (2011) argued that the response decision, which is similar to the outputs described by Davis, would need to be pro-social to be classed as true empathy, since not-acting or enjoying the sensation of negative affect could be seen as a form of sadism. Marshall et al.'s (1995) model has been criticised for having been described as a fixed staged process. However, it includes affective components that are lacking in Davis' (1994) model. The misreading of affective cues has been identified as a particular area requiring further research. Preliminary studies have demonstrated that this may be lacking in some sexual offenders (Gannon, 2009; Pickett, 2007; Wastell, Cairens & Haywood, 2009). Theoretically, being able to empathise with the victim's feelings about a distressing and harmful event would create a psychological barrier to offending as the offender could see the impact of their behaviour. Marshall & Marshall (2011) proposed an updated model of empathy, which included a component for managing personal distress, recognising the difficulties that sex offenders may have in being overwhelmed by the affect of the victim, they may then turn to cognitive distortions to help them self-sooth.

Another way in which to conceptualise empathy, or at least part of the process of empathising, may be an approach promoted by Peter Fonagy and colleagues in the attachment literature: mentalisation. Mentalisation focuses on a persons' ability to use their imagination to perceive and interpret intentional mental states in others. It has been hypothesised that the function of mentalising may be inhibited by the threat of physical violence (Fonagy, 2003), which may be relevant in violent offenders but has not been applied to sexual offenders. The concept of mentalising has also been criticised for being the least novel in its description of a basic human function (Allen & Fonagy, 2006).

Despite the strong explanatory power of empathy as a barrier in the offence cycle (Finklehor, 1984) and the prominence of victim empathy training in SOTPs, recent research evidence indicates that it is not a criminogenic factor. In particular a number of meta-analyses have demonstrated that interventions which increase victim empathy do not significantly contribute to reductions in recidivism (Eastman, 2004; Hanson et al., 2009; Hanson & Morton-Bourgon, 2005). This is possibly due to the difficulties with measurement as current tools for measuring empathy do not take account of the current theories that hypothesise empathy to be a multi-component process (Fernandez & Marshall, 2003; Fernandez, Marshall, Lightbody, & O'Sullivan, 1999; Marshall, Champagne, Brown, & Miller, 1997; Marshall & Moulden, 2001). Therefore much more work is needed to encapsulate empathy as a construct so as to inform effective measurement and intervention strategies. Barriers to offending, such as understanding the distress of the victim, may also be overcome through particular strategies used by sex offenders. For example, using alcohol or offence-related cognitive distortions; such as the victim was complicit because they did not struggle (Baron-Cohen, 2011).

At present the findings of Hanson et al.'s (2009) meta-analysis would need to be treated with caution considering the difficulties with using recidivism rates as outcome measurements from SOTPs. For example: not including a long enough follow-up period to capture reoffending and difficulties with detecting rates of re-offending. Various authors have cited clinical outcomes, how much sex offenders achieve their treatment goals, as being more pertinent over recidivism rates (Grady, Broderson & Abramson, 2011). Principally, the meta-analyses recommended that SOTPs adhere to the risk, need and responsivity principles set out by Bonta and Andrews (2007) to reduce re-offending. These state that human service interventions would need to target treatment at those of greatest *risk* of reoffending. Address criminogenic *need*, which are the factors that contribute to likelihood of reoffending. Finally, treatment should be *responsive* to the learning styles and abilities of the offender in order to maximise efficacy of delivery. For empathy to be comprehensively tested as a criminogenic factor there is a requirement for more research to help refine empathy as a theoretical construct and to then validate these theories. This would impact the development of victim empathy building exercises and inform the measurement of how effective these modules have been. The research

literature identified affective cue discrimination, being able to distinguish between different emotional states, as being an under-researched area and, potentially, the first step in empathising (Gannon, 2009; Pickett, 2007; Wastell, Cairens & Haywood, 2009).

Despite the lack of empirical evidence to validate the inclusion of victim empathy exercises that aim to develop victim empathy in sexual offenders, they are still present in the majority of SOTPs (McGrath et al., 2009). Sexual offenders themselves have also rated the victim empathy component of this work as one of the most important aspects of the course alongside the therapeutic alliance. These take the form of consumer satisfaction surveys on a set number of questions (Bremer, 1992; Colton, Roberts & Vanstone, 2009; Levenson, MacGowen, Morin & Lotter, 2009; Levenson, Prescott & D'Amora, 2010). Wakeling, Webster and Mann (2005) completed a grounded theory analysis of interviews with 46 men on prison SOTPs in England and Wales. Similarly, it was identified that participants seemed to benefit from increased self-awareness, understanding their offence and victim empathy. It is unclear why both offenders and treatment providers seem invested in an aspect of many SOTPs that, as yet, has limited empirical backing.

One explanation may be that clinicians who deliver these programmes have a different set of criteria for assessing risk outside of actuarial risk assessments (Epperson et al., 2005; Prentky & Burgress, 2000). However, it is important to note that many programmes also have a range of tools to maintain treatment integrity such as treatment manuals and regular supervision. Perhaps no relationship exists between the increase in sexual offenders empathy and reductions in recidivism (Joliffe & Farringdon, 2004), but facilitators' perceptions of change in empathy may have an effect on another area that offenders have highlighted as important in treatment; the therapeutic alliance (Bremer, 1992). It has been well documented that therapeutic alliance is a key predictor in psychotherapy and it is partially supported in the literature on sexual offender treatment (Drapeau, Korner, Granger, Brunett & Casper, 2005).

Aims

In light of recent meta-analyses that have identified little empirical link between the inclusion of victim empathy modules in SOTPs and reductions in recidivism rates, it would be important to take account of the research gleaned from offenders stating that it is a useful part of the programme. The aim of this research, therefore, is to explore the perceived value of victim empathy work in SOTPs with the people who are trained to deliver it. This may help to identify other benefits to this work and important directions for future research.

Research questions

1. What are facilitator's views on victim empathy training?
2. If facilitator's perceive an increase in offenders' level of empathy for the victim, does this have any bearing on the therapeutic alliance?

Methodology

Design and method.

The research questions are qualitative in nature because they are explicitly interested in facilitators' views and experiences (Adler, 1996) and will be explored using thematic analysis. Thematic analysis has the benefit of describing the bulk of the data across a number of participant's experiences (Denzin & Loncoln, 2005; Joffe, 2012).

The interviews were all conducted by the primary researcher who was trained in delivering Her Majesty's Prison Service (HMPS) Core SOTP. Reflecting on this process, it allowed the researcher to bypass many of the difficulties with relating to facilitators. For example, the interviewer was already aware of the structure of the programme, the different intricacies of the exercises and the particular jargon used. Lack of experience working with sex offenders has been highlighted as a barrier in other research. Drapeau et al. (2005) described their interviewer, who needed time to adjust to talking about the subject matter, having come from a research background with no clinical experience of sex offenders. It was precisely because the primary

researcher had this background and was perplexed by some of the questions posed in the research literature that this research was undertaken.

Due to the primary researcher's inherent biases, the aim was to make the analysis as transparent and impartial as possible. This was why content analysis was proffered alongside thematic analysis to ensure that particular themes could not be over-weighted (Sandelowski, 2001). Thematic analysis was deemed to be useful in that it is a methodology which is widely used to explore themes occurring across a data set (Fereday & Muir-Cochrane, 2006).

Sample.

Facilitators were sampled from HMPS because it is one of the largest treatment providers in the UK and runs a standardised SOTP (Core SOTP) with a specific victim empathy component. The training of facilitators is standardised including specific advanced training in conducting victim empathy role-plays. They have to meet minimum standards in video-monitored practice, and supervision is standardised. Sexual offenders who take part in Core SOTP meet a minimum standard on IQ measures and actuarial risk assessments, adhering to two parts of the RNR principles. Individuals identified as having high levels of sadism are excluded. Sexual offenders with significant mental health difficulties are treated in secure NHS settings reducing this as a confounding variable in the population facilitators would encounter. Facilitators of HMPS Core SOTP typically come from a range of backgrounds, including psychology staff and prison and probation officers.

Estimating sample sizes for adequate thematic analysis is difficult because it is dependent on the scope of the subject matter and the homogeneity of the group being interviewed; however, Guest, Bunce and Johnson (2006) attempted to address this. They identified when conceptual saturation occurred using thematic analysis with 60 in depth transcripts from women in two West African countries. They concluded that no new themes occurred after 12 interviews and meta-themes were present after 6 interviews. Sandelowski (1995) and Marshall (1996) also highlight 10-12 individuals as being an adequate number for useful thematic analysis.

The sample consisted of 12 facilitators across four prison sites; HMPs' Bullingdon, Channingswood, Shepton Mallet and Whatton. Demographic details are provided in Table 1. Four prison sites were sampled in an effort to maximise the number of potential participants and to reduce possibility of prison-specific practices, cultures and attitudes influencing the results. All facilitators who responded to the advertisement took part in the study.

Table 1

Sample demographic information

Demographic variable	Frequency
Age	*M* = 37 (*SD* = 9.5, Range = 29-55)
Gender	9 females, 3 males
Profession	8 Psychology staff, 4 Prison Officers
No. groups completed	*M* = 3.1 (*SD* = 1.21. Range = 2-5)
Length of time between groups	*M* = 1yr, 8mths (*SD* = 10.5mths)

All facilitators had facilitated a programme within two years of the interview, 11 in the same year of interviewing. All facilitators had also completed the advanced training in delivering victim empathy role plays.

Procedure.

Following approval from the University of Exeter's Ethics committee (please see appendix A) and subsequent approval from the National Offender Management Service (NOMS; appendix B), an email advertisement for participation was sent to the treatment and programme managers at each prison site. The advertisement included an electronic copy of the ethical approval documents, participant information sheet with details to contact the research team (appendix C) and consent form (appendix D).

Facilitators were interviewed in their respective prison locations, in order to be the least disruptive and demanding option for prison resources. At interview we ran through the confidentiality and consent agreement, completed the interview battery (appendix E), and provided debrief for participants (appendix F).

The semi structured interview (appendix E) was designed with open questions to see if concepts of victim empathy emerged naturally, and if so, whether they linked in any way to the therapeutic alliance. Finally facilitators were asked for their view on the discordant research in this field, the qualitative research that suggests SOTP participants find victim empathy to be one of the most important aspects, and the meta-analysis work which has found no link between victim empathy training and reductions in recidivism. The audio-taped interviews were then transcribed for analysis.

Ethical approval and considerations.

Speaking about their work with sexual offenders may have been distressing for facilitators particularly if they were recounting times where a therapeutic alliance was difficult to form. Consideration was given to respecting the professionalism of facilitators as asking them questions about efficacy of certain aspects of the SOTP may have undermined the integrity of the training they had received. Facilitators were reminded of support networks available through their work when talking about this topic as these are specifically tailored to supporting facilitators on SOTPs. Confidentiality of prisoners was maintained because participants were asked about process rather than about specific offenders.

Facilitators were informed that confidentiality would have to be breached if they were talking about harm to themselves or others or there was an infringement of prison service protocol. Facilitators' data was made anonymous and kept securely. They were informed of their right to withdraw consent and have their data destroyed up until the point of anonymous transcription.

Analysis

The qualitative analysis strategy involved two processes; to supplement the thematic analysis, content analysis was also used to rank the amount of codes present in the data (Miles & Huberman, 1994; Leech & Onwuegbuzie, 2007; Onwuegbuzie & Leech, 2004). Sandelowski (2001) stated that counting codes in this way prevents the

researcher from over or under weighing emergent themes. It also gives an overall picture of the range and frequency of codes to supplement the thematic analysis where key themes will be focussed on to answer the research questions. Spencer and Ritchie (2012) argued that data triangulation of this nature allows for greater validation of the inferences drawn from the thematic analysis.

The analysis strategy initially involved reading through the literature review and transcribed interviews. The available information was then segmented into meaningful analytical units and marked with descriptive words to act as codes. This process was undertaken using the qualitative statistics package, NVivo. The following example was coded as *Therapeutic Relationship - Quality*:

> *"I kind of think about how I would want the therapist to kind of react to me. I wouldn't want them to be bored or aggressive. I would want them to be warm and understanding" (Facilitator 3)*

Deductive codes were generated from the literature review. Inductive codes were created by examining the transcribed interviews and iterative codes were fashioned from the repeated process of comparing and interrogating the emerging code book. Iterative codes were elicited through comparing all deductive and inductive codes to condense repeating and similar codes (see table 2 for number of codes before and after iteration).The final set of iterative codes were then compiled and described in a code book (see appendix G). For example:

> *Therapeutic Relationship – Quality: A description of particular qualities that make the relationship therapeutic and distinct from other kinds of relationship. For example, working or interpersonal.*

Table 2

Process of compiling and condensing codes

Type of codes	Number of codes
Deductive	29
Inductive	616
Iterative	145

Reliability.

To test the transparency of the code book, two independent coders used it to blind-code three random transcripts. Joliffe (2012) recommended that between 10-20% of the data be used to test transparency. Checking codes in this way allowed the code book to be more transparent and clearer to apply when generating themes (Maxwell, 2005; Merriam, 1998). Agreement between raters was achieved 66.6% of the time (see table 3); the calculated Kappa coefficients of .66 were significant at $p < .0001$ and fitted the criteria for 'substantial chance-corrected agreement' (Landis & Kock, 1977) for this code book.

Table 3

Raters level of agreement on coding

Coding decisions	Number of excerpts
Total rated	314
Rated the same	209
Rated differently	105

After checking for agreement, the raters compared non-agreed codes. Discrepancies between coding decisions were then discussed in order to thicken the rigor of the analysis process and develop thinking around themes (Cohen, 1960). A number of codes were identified as being equally applicable. For example the excerpt below could be coded with the following two codes; *Therapeutic Relationship – Quality* and *Facilitator – Empathy*.

"I kind of think about how I would want the therapist to kind of react to me. I wouldn't want them to be bored or aggressive. I would want them to be warm and understanding" (Facilitator 3)

When the 105 coding discrepancies were examined, 58 were deemed to work concurrently and accepted into the agreement rating. Kappa was then recalculated which resulted in .84 ($p < .0001$), falling within the 'excellent chance-corrected agreement rating' (Landis & Koch, 1977). From rater discussions, five code descriptions were clarified and 6 additional codes were generated. Once the 151 code book had been finalised (see appendix G) this was then re-applied to the entire data set of 12 transcripts.

Content analysis results.

Descriptive statistics for all coding can be found in appendix H. Content analysis identified that 8 codes occurred in all transcripts (see table 4).

Table 4

Codes present in all transcripts

Code	Number of times code is used
Victim empathy – Caveat	59
Individualised	54
Difficult group members – Traits	45
Facilitator – Enjoy	41
Insight	34
Victim empathy – Indirect	33
Therapeutic relationship – Quality	28
Victim empathy – Intervention	27

It was also identified from this analysis that 47 codes repeated 14 times or more across the different transcripts but not necessarily in all transcripts (see appendix H). These codes, once combined, accounted for roughly a third of the code book (55 codes). See table 5 for the total number of codes accounted for by these 55 codes.

Table 5

Number of codes accounted for by different code arrangements

Arrangement of codes	Number of times used
All codes in all transcripts	1924
Codes accounted by 55 interrogated codes	1359
Codes accounted by 22 code model	688

Analysis was then run through NVivo, to identify which of these codes co-occurred or were next to each other in the text by a margin of five words. Codes that fitted this criterion 25% or more as a function of their total use in the texts accounted for 22 associations between 21 of the codes of interest for generating themes.

A model of associations was then generated to help conceptualise this data, including codes which occurred in all the transcripts (see figure 1). Once the model was developed the primary researcher returned to the 688 excerpts, which were accounted for by the 22-code model, and used both the model and the excerpts to develop themes using the method described by Joffe (2012). This involves making a transparent trail, so that it is clear what is present within the data. The following section 'thematic analysis' will detail the narrative from which themes were generated. Using content analysis in this way allowed for the themes generated to be weighted and couched by the data.

As can be seen from figure 1, the particular codes used to generate themes have been clustered and sectioned off. Once the six themes were generated it was possible to cluster these according to three meta-themes because they shared particular features, which will be described in the following section.

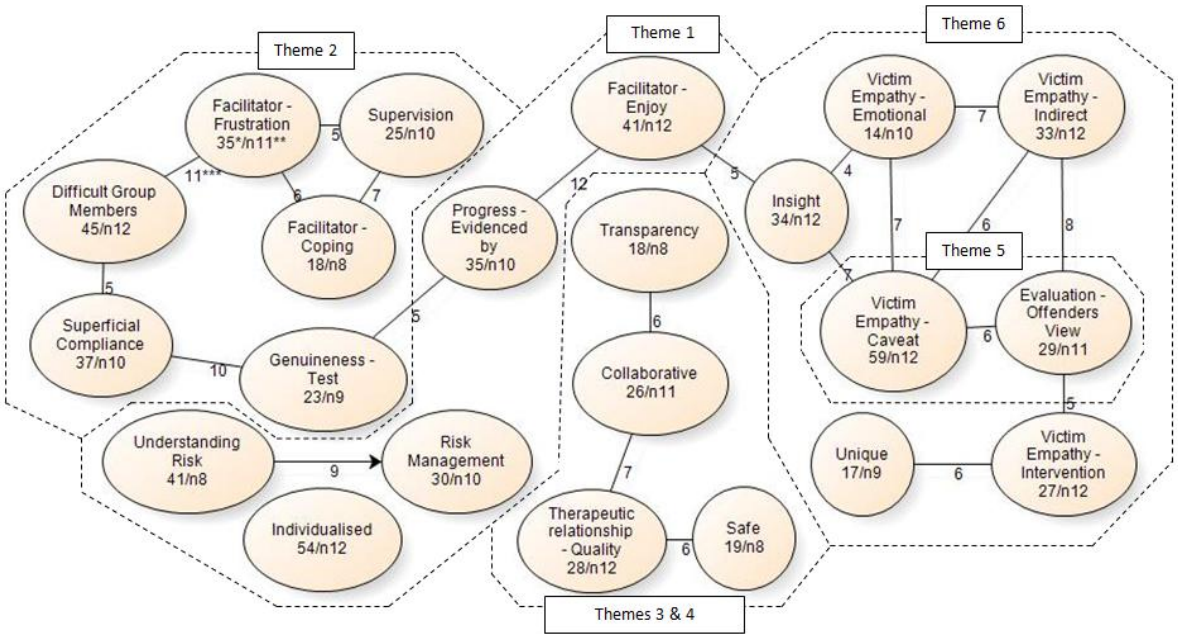

Figure 1. 22-code model of associations. The following key explains numbers and lines: (*total occurrence of code in transcripts; **number of transcripts the code appears in; ***number of times the two codes occur together; ---- Indicates the boundary of a them; solid line indicates codes which occur together; arrow indicates direction of effect).

Thematic analysis results.

The following subsections will seek to explain the central themes which were generated using the 22-code model (see figure 1) and excerpts to build a narrative from which the themes were compared and checked. Each subsection is titled with the meta-themes in bold italics. These subsections then provide a narrative, from which themes were developed, using the codes and excerpts in the 22-code model. Finally each subsection lists the themes which were derived from the narrative. The meta-theme-theme-code arrangement can be seen in table 6.

Table 6.

Arrangement of codes under theme and meta-themes

Meta theme	Theme	Codes clustered under theme
What facilitators enjoyed and were frustrated by in their work	Facilitators valued and enjoyed participants' perceived progress through treatment.	Facilitator-enjoy Progress-evidenced by Understanding risk Risk management Individualised
	They wrestled with frustrations linked to difficult group members, where onus then switched to testing for genuineness.	Facilitator-frustration Supervision Facilitator-Coping Difficult group members Superficial compliance Genuineness test
The particular role of the therapeutic relationship	Facilitators modelled an honest, open and genuine relationship, to enable participants to do the same.	Transparency Collaborative Therapeutic relationship-quality Safe
	Participants' reaction to the therapeutic relationship could be used as evidence of their genuineness.	Transparency Collaborative Therapeutic relationship-quality Safe
The particular role of victim empathy training	Facilitators were concerned that the perceived impact of victim empathy could be superficial compliance, although the affective component helped to clarify genuineness.	Victim empathy – caveat Evaluation – offenders view
	The particular emotional aspect of VE role play training may help facilitators to empathise with difficult group members.	Victim empathy – emotional Victim empathy – indirect Insight Unique Victim empathy – intervention

What facilitators enjoyed and were frustrated by in their work.

Facilitators identified that understanding risk, leading to risk management, was the main purpose of therapy and that anything which contributed to this process could be considered 'effective'. All facilitators noted that the interaction between facilitator, therapy and participants was unique and dependent on individual factors. Thus, they identified that this process would have to be individualised. It is important to bear this in mind as a caveat for any of the subsequent conclusions drawn from the data.

The third most commonly occurring code pertained to the different traits of difficult group members which facilitators felt was not conducive to effective treatment. What facilitators found most difficult was when group members were insulting or had 'a personality clash'. Facilitators also found it difficult to work with participants who, they felt, were resistant, avoidant or in denial. It was less common for group members to be particularly aggressive or needy.

As a result of these difficulties, facilitators described becoming frustrated and then needed to rely on their support networks to manage this. They identified supervision and using humour with other members of the team as particularly important ways of coping with the stress generated through working with difficult group members.

> *"I think we have a laugh and a joke in the team. You know; got the slightly black, twisted sense of humour that often comes out."*
> *(Facilitator 4)*

There was conceptual overlap between the traits of difficult group members and what was coded as 'superficial compliance', this focussed on facilitators being concerned that participants were 'telling them what they want to hear'.

"I don't know if it is lip service, if it is on a superficial level. Perhaps, if they do get that understanding of it, but don't really take it on board." (Facilitator 2)

Facilitators spoke about ways in which they could go about testing for how genuine participants were being on the programme. There were two general approaches to testing for genuineness: cognitive and affective. The cognitive component involved questioning participants further to see whether they were able to give more detail to their responses. If participants contradicted themselves or were unable to elaborate, this could be seen as evidence of them being disingenuous. For example:

"When we ask them that question (what will stop you from offending?), *they kind of give you the standard 'yeah I'll think of my victim' but we need to say; 'how are you going to do that then? What is that information going to help you with?' So, just making it really clear." (Facilitator 3)*

The affective component focussed on times when participants demonstrated emotions. When facilitators noticed these, they considered participants were being more genuine, as they felt the emotions were difficult to fake. This was particularly clear from participant's body language; if they were crying, shaking or 'had a look in their eyes'. For example:

"It's almost like a light bulb moment. Yeah, they go very quiet and it's very hard to describe it. You can see that it's had some sort of impact on them." (Facilitator 5)

Facilitators were highly invested in seeing participants progress through the programme. Progress was evidenced by participants demonstrating that they understood their risk factors for reoffending and addressed these through appropriate risk management strategies. A concept that was linked to this was participant's level of insight into their offending.

"You want them to recognise that nothing about what they did was ok." (Facilitator 1)

Some offenders may also present with feelings of sadness for themselves and their situation. Facilitators recognised that this may be frustrating and they seemed very concerned about not being the aggressor in the relationship.

> *"We're not trying to get them on a programme so that we can then knock them down and say actually, 'you're not the victim, they were'."*
> *(Facilitator 1)*

Facilitators enjoyed their work when they could see participants progress and evidence of their insight developing. This code was the fourth most prevalent in all transcripts (see table 4).

> *"I love seeing somebody come on the group, maybe with really low self esteem, or maybe has just never talked about his offending, and see him kind of progress through the programme. See them move and sort of blossom and end up with quite good levels of self esteem. Happy talking to female members of staff, can have a laugh and a joke, you know, all that sort of stuff." (Facilitator 4)*

The following themes were generated from this data:

1. Facilitators valued and enjoyed participants' perceived progress through treatment.
2. They wrestled with frustrations linked to difficult group members, where onus then switched to testing for genuineness.

The particular role of the therapeutic relationship.

In terms of the therapeutic relationship, facilitators felt this was best described as a relationship which fostered participants' openness to disclose their offending in an honest way. They felt it necessary for participants to feel safe to do this. Particular qualities which helped with this were collaborating with participants and recognising

that the process was for their benefit. They felt that good therapeutic relationships contributed to the process of understanding and managing risk.

Facilitators also spoke about the importance of being transparent in their interactions with participants. They modelled an open and honest relationship in an effort to enable participants to reciprocate. Facilitators recognised that how participants responded to this relationship could provide evidence for how genuine they were in engaging in treatment.

> *"The therapeutic relationship is more about the positive relationship with staff, and people in general, which they can use again in future and it almost helps them become their own facilitator." (Facilitator 12)*

The following themes were generated from this data:

3. Facilitators modelled an honest, open and genuine relationship, to enable participants to do the same.
4. Participants' reaction to this relationship could be used as evidence of their genuineness.

The particular role of victim empathy training.

The code that was mentioned most often in all transcripts was that victim empathy training carried a great number of caveats as to its importance for participants and the treatment as a whole (see table 4). Facilitators were very aware of the dilemma in the research literature between the outcome studies that do not support victim empathy training and feedback from participants favouring it. The caveats included the following: facilitators conceptualised empathy for victims as a skill, it was only useful if it helped participants with understanding risk and then contributed to the strategies used to manage those risks. They reconciled the research literature by stating that victim empathy training may only have an impact in the short term and the treatment effect may not last long enough to impact on recidivism rates. They also

considered that victim empathy is only part of a range of interventions used on the programme and should be thought about in this wider context.

Given the particular reservations facilitators had about victim empathy training, they were highly aware of the impact or power this part of the programme had over participants. This was particularly related to participants seeming to understand the gravity of their offence and having a 'eureka' moment. This was linked to the previously described concept of 'insight'.

> *"In the last few groups I've delivered, if I've had particularly resistant group members at the beginning I've thought 'it's ok, just wait until we get to victim empathy'". (Facilitator 12)*

However, facilitators were concerned about participants' reactions to the victim empathy training block; since it was the offenders themselves who said it was important, it was difficult for facilitators to know whether they were being genuine or 'superficially compliant'.

> *"I think some pick up on the fact that others do show empathy and win some brownie points because, you know, it's good to have victim empathy. I think some of them perhaps pick up on that. It's quite a buzz word, having victim empathy." (Facilitator 5)*

Facilitators commented that empathising with victims of sexual abuse is a socially desirable trait. This is evidenced by parole boards and probation service pre-sentence reports favouring treatment goals that focussed on it, despite the empirical evidence to the contrary. Facilitators were concerned that participants may be highly aware of this and act accordingly.

Facilitators noted that there were particular aspects of victim empathy training that were unique. For example, it was the only part of the programme where participants are encouraged to explicitly adopt points of view other than their own. They wondered whether it might be easier to accept risk factors when seeing them from another person's point of view. They also stated that victim empathy training

tended to elicit more emotions, which fed back into the affective component of testing for participants' genuineness.

> *"Like I say victim empathy is really the emotional part of the programme and like, the eureka moment for some guys." (Facilitator 10)*

However, facilitators were also mindful that this process could be punishing and they did not want participants to experience this. Facilitators felt that connecting emotionally with others was something lacking generally in group participants.

Facilitators spoke about one way in which victim empathy training could strengthen the therapeutic alliance. They were able to empathise with group members who were finding the victim empathy exercises difficult, noting that whilst this happened throughout the programme, it was particularly poignant during the victim empathy training block. This process was also something that facilitators valued and enjoyed about their work.

The following themes were generated from this data:

5. Facilitators were concerned that the perceived impact of victim empathy could be superficial compliance, although the affective component helped to clarify genuineness.
6. The particular emotional aspect of victim empathy role play training may help facilitators to empathise with difficult group members.

Outliers/additional findings.

There were a number of excerpts which seemed to go against the overall caveat that group participants should only be seen as individuals. There were particular concerns with paedophilic offenders. Some facilitators stated that because of the nature of the offence, paedophiles were the most difficult to empathise with. This may have been due to these facilitators having children of their own, a question that was missing from the original interview battery.

> *"I think about my child and think 'oh my god, how could you do that?' but I do try not to." (Facilitator 1)*

A further complicating factor may be the perceived fixed nature of paedophilia as a sexual interest.

> *"I think the sexual interest part is really important because I know myself that if somebody asked me to change my sexuality, I'd be like 'where do you start?' I couldn't imagine how difficult that would be." (Facilitator 7)*

It also seemed that some facilitators used their own 'cognitive distortion' to help them connect with participants, by focussing on particular aspects of the person.

> *"But, most of the time I've worked with people who have been quite likeable, but they've just committed horrible offences. It's easy for you to just kind of separate things out." Facilitator 3*

A further discrete finding was that the victim empathy component may help offenders challenge child abuse supportive beliefs (13 codes across 8 interviews) particularly the cognitive distortion that the child consented to sexual contact. Finally, one facilitator summed up the caveat that even if participants seemed to do well on the programme, this does not necessarily reduce risk if other factors are not managed effectively.

> *"Although they say it has a big impact on them they can still go on to offend. I think if you got all the other factors beforehand. Inadequacy kicks in; they can't solve problems, down on their luck, isolated, no job and world sort of crumbling around them. They want to feel good. If they have a sexual preference for children and they're on the computer, then they wouldn't think about their victim." (Facilitator 8)*

Returning to the research questions.

1. What are facilitator's views on victim empathy training?

It seems that facilitators found victim empathy training to be an effective part of treatment. However, they noticed a great range of caveats alongside this. They considered it only as part of a wide range of interventions, that it's specific to individuals, and that they needed to be careful not to be punishing. They identified that the effects may not last long and that it bleeds into other areas of the programme. They speculated that it may also be easier for participants to accept risk factors or disclose from a different perspective. Finally, facilitators considered the problem that participants may think it is socially desirable to have empathy for victims and superficially comply with this aspect of the programme.

On a clinical-interaction level facilitators reported victim empathy training as useful for driving insight, especially for particularly stuck individuals. This may not directly link to reducing recidivism but may feed in to other areas of the programme that are more effective. The more emotional flavour of victim empathy training also helped facilitators to confirm whether participants were genuine.

2. If facilitator's perceive an increase in offenders' level of empathy for the victim, does this have any bearing on the therapeutic alliance?

It seemed as though the victim empathy components allowed facilitators to empathise with difficult group members. However, this also happens throughout the programme, so may not appear to be restricted to victim empathy. A discrete set of data indicated that when participants who have offended against children develop empathy, it may help particular facilitators to develop their therapeutic relationships.

Discussion

The research highlighted that victim empathy training may be a useful component of treatment: however there seems to be a number of caveats to this conclusion, not least the discrepancy between quantitative and qualitative research

findings about its effectiveness. Generally, facilitators identified that there were no overriding risk factors that should be considered in treatment, but thought that treatment needs would be individualised for each participant. The results identified that victim empathy training may not impact on the therapeutic alliance any more so than other modules of the programme.

The qualitative methodology allowed for a greater exploration of ideas in the data. This raised some interesting questions which will be partially addressed in this discussion section. Particularly, the way in which the emotional aspects of victim empathy training may help facilitators to connect with difficult group members and, perhaps to a lesser extent, challenge paedophilic offenders' views. In considering these questions we will draw on psychodynamic ideas, in particular the mentalising literature and Karpman drama triangle. Finally, we will consider the emerging attachment literature which could have relevance to the therapeutic alliance.

Since SOTPs have the primary aim of reducing the risk of future offending, facilitators and offenders are motivated to demonstrate this. As such, SOTP facilitators can find themselves in a difficult therapeutic position. Their clients come to therapy possibly with other motives in mind, like meeting sentence requirements for example, rather than just addressing their offending. Interestingly, Drapeau et al. (2005) identified from their research that none of the sex offenders they questioned felt they needed help with a sexual problem. It seems as though some of the work facilitators undertake on SOTPs involves testing how genuine participants are in coming to therapy.

The results highlighted that facilitators test for participant genuineness in two ways: firstly, eliciting from participants an extended cognitive understanding of their risk factors and how they can address these in the future. Secondly, generating some emotional valence as facilitators felt this was hard to fake. This overlaps with models of empathy proposed by Marshall, Jones and Fernandez (1995) and Davis (1994), which compartmentalise empathy into cognitive and affective components. Facilitators noticed that victim empathy training in particular may elicit strong emotions and could be difficult for participants to experience. The dilemma may be that pushing participants too hard to connect with the emotional aspects of these

exercises, to test their genuineness, may encourage those who are more ambivalent to drop out. Treatment drop out is associated with higher rates of reoffending (Hanson, Bourgon, Helmus & Hodgson, 2009). This may have relevance to the mentalising literature since this also makes the distinction between genuine and non-genuine empathising.

Allen and Fonagy (2006) described the phenomena of pretend mode in mentalising, which is having a cognitive understanding of another's mind but without the affective component. This is, perhaps, similar to the facilitators' worries that the participants could be superficial in their compliance with the programme. For example, the participant may have an intellectual understanding that the victim may struggle to form secure sexual relationships later in life because of the abuse, but they may not have an empathic reaction to this understanding. It may be useful for future research to consider mentalising techniques when developing victim empathy training exercises for sex offenders.

However, there are some specific limitations with applying the mentalising literature. Mentalising is described as a higher order function, typified as having a curiosity about the minds of others rather than 'knowing' what others are thinking or feeling (Allen & Fonagy, 2006). Whilst victim empathy role-play exercises come close to this, the agenda of harm reduction and risk management does not allow the facilitator to entertain a curious stance about every perspective the victim could hold. For example, a commonly reported cognitive distortion by participants is that the victim wanted the sexual contact (Bumby, 1996). Facilitators cannot condone the possibility that the victim actually did want the sexual contact, because the precept in HMPS SOTP is the participant is guilty. This means the facilitator has to take the perspective that the victim was unable, through whatever means, to consent to the sexual contact.

Having discussed some of the results regarding the particular benefits of victim empathy training using a psychodynamic approach, we will now consider the impact on the therapeutic relationship. The dilemma of testing for participant genuineness, faced by Core SOTP facilitators, may have relevance to the Karpman drama triangle (Karpman, 1968), a method of thinking about reciprocal relationships

which could also play out in the therapy room. This was developed in the transactional analysis field as part of game theory. Within this model a person could adopt the position of persecutor, victim or rescuer. Although employing the common use of these labels could be misleading, since for example, the victim may not be powerless and the rescuer not at all helpful.

Within the context of SOTPs it may be that the roles of facilitator and participant are very clearly pre-determined in the triangle since it may be assumed that the victim cannot be considered anything other than victim. Within the drama triangle, however, roles can change and it may be that facilitators become frustrated with the difficult or resistant participant not accepting help. This could be a useful model for facilitators to use in supervision to help formulate difficult therapeutic relationships which can act as a proxy for other relationships in the client's life (Gilbert & Leahy, 2007).

The results also identified a discrete finding that facilitators may use a particular cognitive distortion to reconcile difficult therapeutic relationships. For example, stating that they try to look past the offence or see the offence as 'behaviour' and the rest as person. This is similar to the psychodynamic concept of 'splitting' (Klein, 1946). This finding has been replicated in other research. For example, Sandu, Rose, Rostill-Brookes and Thrift (2012) identified that facilitators may attempt to not think about the victim whilst working with the offender because it is too difficult and interferes with the therapeutic approach. However, this strategy of splitting off parts of the participant may not be viable or realistic in the case of paedophilic offenders, as sexual interests contribute to core sense of self and identity in humans (Hines, Brook & Conway, 2003).

Another emerging area of research, which may have relevance to facilitators forming therapeutic relationships with participants, is concerned with attachment disorders in sex offending. Prevalence figures reveal that offenders with attachment disorders are more likely to have committed serious crimes (Lader, Songleton & Meltzer, 2003; Powis, 2002). The presence of attachment disorder was also a predictive factor for distinguishing between juvenile sexual and non-sexual offenders (Salat, 2009), highlighting the prevalence of attachment problems in this group.

Craissati, Webb and Keen (2008) advocated for the importance of measuring developmental variables, considering the strong relationship between early attachment problems, later personality disorder development and the increase in risk of sexual recidivism. Larochelle, Diguer, Laverdière and Greenman (2011) also noted, from an analysis of 18 outcome studies, that antisocial personality disorder predicted treatment drop out in sexual offenders. This research base is developing and further research is required. However, it may be helpful to look at group members attachment styles, to help facilitators to be open about the way participants relate with others. Facilitators may also then know what to expect with participants who have had difficult attachment experiences. It is important to note that some theories of empathising have been developed from the attachment literature, including Marshall et al.'s (1995) model of empathy and the concept of mentalising.

Limitations of the research.

This study sampled research participants from a fairly homogenous group of SOTP facilitators, therefore, these findings are limited to a specific group and may not have relevance for other facilitators in different treatment areas. Clinicians' ability to accurately discern risk in sexual offenders has also been challenged in favour of statistical risk assessment protocols (Grove, 2005), which may limit the usefulness of these findings. Therefore facilitators' belief that offenders who have victim empathy, insight and genuineness contribute to treatment effectiveness, as evidenced by this research, may be mistaken. It is also important to note that even if participants are being genuine in their empathy and treatment goals this still may not be enough to desist from offending, given the right conditions. Future research studies may benefit from a synthesis of qualitative and quantitative methodologies which follow offenders longitudinally to assess impact of treatment quality on reoffending.

This research could also have benefitted from eliciting more information from facilitators about their personal experiences, for example, whether they had children of their own and if this impacted on their work. Very few facilitators offered to comment on their personal circumstances.

There was also an inherent bias of having an ex-SOTP facilitator as the primary researcher. Although triangulation of analyses was used to reduce researcher influence, this could still have impacted on the results and findings. It may perhaps be useful to include standardised questionnaires in future research, as has been the favoured methodology for research into SOTP participants' views.

Recommendations for developing theory, practice and continuing research.

- This research suggests that there are some useful aspects to retaining victim empathy training in HMPS Core SOTP. It may be useful to consider how the particular emotional aspect of this component may contribute to treatment effectiveness and perhaps the ability of facilitators to develop therapeutic alliance with difficult group members in future research.

- Neither Marshall, Jones and Fernandez's (1995), nor Davis' (1994), models of empathy include components which look at the way empathising can be selective through the use of cognitive distortions. The research literature suggests that sex offenders use these to justify their offending and the results suggest facilitators use them, to a degree, to empathise with their clients.

- The majority of research literature on SOTP facilitators focuses on burn-out (Ennis & Home 2003; Nelson, Herlihy & Oescher, 2002). What is clear from this research is that facilitators value supervision and their own intra-group support networks. What may help clinicians working on SOTPs is building on this strength, bringing different models to help conceptualise their interactions with participants and to be more focussed on the impact of the therapeutic relationship. These experiences may then bolster offenders' relationships outside of the therapy room. For example, having supportive families has been shown to be a protective factor for juvenile sexual offenders (Bischof, Stith & Whitney, 1995).

Conclusion

In summary, this research has investigated whether, similar to participants, facilitators on Core SOTPs believe that victim empathy training is useful or not. It appears from this research, that whilst there is support for this aspect of treatment, facilitators are far more cautious about it then participants. This is perhaps not surprising as another aspect of the dynamic between participant and facilitator emerged as a precedent in this process: congruence. Facilitators could not be sure that participants were being genuine, but highly emotive aspects of the programme helped when making this decision. However, even this is tenuous because the assumption that the offender has that degree of control over his future offending behaviour may be false. As may be an uncomfortable truth for SOTP developers, systemic and biological pressures clearly also play a key role in recidivism and desistence. What the facilitator and supervisor can do in the mean time is to focus on the meanings of their relationships with group participants and to use support networks to manage the stress of the work.

References

Adler, L. (1996). Qualitative research of legal issues. In *Research that makes a difference: Complementary methods for examining legal issues in education*. (No 56, pp. 3-31). Topeka, KS: NOLPE.

Allen, J.G. & Fonagy, P. (2006). *Handbook of mentalization-based treatment.* Chichester, UK: John Wiley.

Barabree, H.E. & Marshall, W.L. (1988). Deviant sexual arousal, offence history and demographic variables as predictors of re-offence among child molesters. *Behavioural Sciences and the Law, 6*, 267-280.

Baron-Cohen, S. (2011). *Zero degrees of empathy: A new theory of human cruelty*. London: Penguin.

Bischof, G.P., Stith, S.M. & Whitney, M.L. (1995). Family environments of adolescent sex offender sand other juvenile delinquents. *Adolescence, 30* (117), 1-11.

Bonta, J. & Andrews, D.A. (2007). *Risk-need-responsivity model for offender assessment and rehabilitation* (Corrections Research User Report No 2007-06). Ottawa. Onatrio: Public Safety Canada.

Bremer, J.F. (1992). Serious juvenile sex offenders: Treatment and long-term follow-up. *Psychiatric Annals, 22* (6), 326-332.

Browne, E. & Finkelhor, D. (1986). Impact of sexual abuse: A review of research. *Psychological Bulletin, 99*, 66-77.

Bumby, K.M. (1996). Assessing the cognitive distortions of child molesters and rapists: Development and validation of the MOLEST and RAPE scales. *Sexual Abuse: A Journal of Research and Treatment, 8* (1), 37-54.

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement, 20*, 37–46.

Colton, M., Roberts, S. & Vanstone, M. (2009). Child sexual abusers views on treatment: A study of convicted and imprisoned adult male sexual offenders. *Journal of Child Sexual Abuse*, 18, 320–338

Craissati, J., Webb, L. & Keen, S. (2008). The relationship between developmental variables**,** personality disorder, and risk in sex offenders. *Sexual Abuse: Journal of Research and Treatment, 20* (2), 119-138.

Davis, M. H. (1994). *Empathy: A social psychological approach*. Dubuque, IA: Brown & Benchmark Publishers.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2005). *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Drapeau, M., Korner, A., Granger, L., Brunet, L., & Casper, F. (2005). A plan analysis of sexual abusers motivations for treatment: A qualitative pilot study. *International Journal of Offender Therapy and Comparative Criminology, 49*, (3), 308-324.

Eastman, B.J. (2004). Assessing the efficacy of treatment for adolescent sex offenders: A cross-longitudinal study. *The Prison Journal, 84* (4) 472-485.

Epperson, D.C., Ralston, C.A., Fowers, D., DeWitt, J & Gore, K.S. (2005). Actuarial risk assessment with juveniles who offend sexually. In *Risk Assessment of Youth who have Sexually Abused. Theory, controversy and emerging strategies*. (1st ed., pp. 118-170). Oklahoma. Wood and Barnes Publishing.

Ennis, L. & Home, S. (2003). Predicting psychological distress in sex offender therapists. *Sexual Abuse: A Journal of Research and Treatment, 15* (2), 149-157.

Fereday, J. & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative methods, 5*, 1-11.

Fernandez, Y.M., & Marshall, W.L. (2003). Victim empathy, social self-esteem and psychopathy in rapists. *Sexual Abuse: A Journal of Research and Treatment, 15*, 11-26.

Fernandez, Y.M., Marshall, W.L., Lightbody, S., & O'Sullivan, C. (1999). The Child Molester Empathy Measure: Description and an examination of its reliability and validity. *Sexual Abuse: A Journal of Research and Treatment, 11*, 17-31.

Fonagy, P. (2003). Towards a developmental understanding of violence. *The British Journal of Psychiatry, 183* (3), 190-192.

Finkelhor, D. (1984). *Child sexual abuse: New theory and research.* New York: Free Press.

Gannon, T.A. (2009). Social cognition in violent and sexual offending: an overview. *Psychology, Crime and Law,* 15 (2-3), 97-118.

Gilbert, P. & Leahy, R.L. (2007). *The Therapeutic Relationship in the Cognitive Behavioural Psychotherapies.* London, Routledge.

Grady, M.D., Broderson, M. & Abramson, J.M. (2011). The state of psychological measures for adult sexual offenders. *Aggression and violent behaviour, 16*, 227-240.

Grove, W.M. (2005). Clinical versus statistical prediction: The contribution of Paul E. Meehl. *Journal of Clinical Psychology, 61* (10), 1233-1243.

Guest, G., Bunce, A. & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18* (1), 59-82.

Hanson, R.K., Bourgon, L.H., Helmus, L. & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice & Behaviour, 36,* 865-891.

Hanson, R.K. & Morton-Bourgon, K.E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism rates. *Journal of consulting and counselling psychology, 73* (6), 1154-1163.

Hanson, R.K., Gordon, A., Harris, A.J.R., Marques, J.K., Murphy, W., Quinsey, V.L. & Seto, M.C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14,* 169-193.

Hines, M., Brook, C. & Conway, G.S. (2003). Androgen and psychosexual development: Core gender identity, sexual orientation, and recalled childhood gender role behaviour in women and men with congential adrenal hyperplasia (CAH). *Journal of Sex Research, 41* (1) 75-81.

Hodges, S. D., & Wegner, D. M. (1997). Automatic and controlled empathy. In *Empathic Accuracy* (1st ed., pp. 311–339). New York: The Guilford Press.

Hoffman, M. L. (2000). *Empathy and moral development: Implications for caring and Justice.* New York: Cambridge University Press.

Joffe, H. (2012). Thematic analysis. In *Qualitative Research Methods in Mental Health and Psycholotherapy. A guide for students and practitioners* (1st ed., pp.209-224). Oxford: Wiley-Blackwell.

Jolliffe, D., & Farrington, D. P. (2004). Empathy and offending: A systematic review and meta-analysis. *Aggression and Violent Behavior, 9*, 441−476.

Karpman, S. (1968). Fairy tales and dream analysis. *Transactional Analysis Bulletin, 7* (26), 39-43.

Klein, Mélanie (1946). "Notes on some schizoid mechanisms". *Envy and gratitude and other works 1946-1963*. Hogarth Press and the Institute of Psycho-Analysis

Lader, D., Singleton, N. & Meltzer, H. (2003). Psychiatric morbidity among young offenders in England and Wales. *International Review of Psychiatry, 15*, 144–147.

Landis, J.R. & Koch, G.G. (1977). The measurement of observer agreement for categorical data. *Biometrics, 33*, 159-74.

Langevin, R., Ben-Aron, M., Couthard, R., Heasman, G., Purins, J., Handy, L., Hucker, S.J., Russon, A.E., Day, D., Roper, V., Bain, J., Wortzman, G. & Webster, C.A. (1985). Sexual aggression: Constructing a predictive equation. In *Erotic Preference, Gender Identity and Aggression in Men* (1st ed., pp.39-76). Hillsdale, NJ: Earlbaum.

Larochelle, S., Diguer, L., Laverdière, O. & Greenman, P.S. (2011). Predictors of psychological treatment noncompletion among sexual offenders**.** *Clinical Psychology Review, 31* (4) 554-562.

Leech, N. L. & Onwuegbuzie, A. J. (2004). Enhancing the interpretation of "significant" findings: The role of mixed methods research. *The Qualitative Report, 9,* 770–792.

Levenson, J.S., MacGowan, M.J., Morin, J.W. & Lotter, L.P. (2009). Perception of sex offenders about treatment: Satisfaction, engagement in research and treatment. *Sexual Abuse: A Journal of Research and treatment, 21* (1), 35-56.

Levenson, J.S., Prescott, D.S. & D'Amora, D.A. (2010). Sex offender treatment: consumer satisfaction and engagement in therapy. *International Journal of Offender Therapy and Comparative Criminology, 54* (3), 307-326.

Marshall, M.N. (1996). Sampling for qualitative research. *Family Practice, 13* (6), 522-525.

Marshall, W. L., Hudson, S. M., Jones, R., & Fernandez, Y. M. (1995). Empathy in sex offenders. *Clinical Psychology Review, 15*, 99−113.

Marshall, W.L., Champagne, F., Brown, C., & Miller, S. (1997). Empathy, intimacy, loneliness, and self-esteem in non-familial child molesters. *Journal of Child Sexual Abuse, 6*, 87-97.

Marshall, L.E. & Marshall, W.L. (2011). Empathy and antisocial behaviour. *The Journal of Forensic Psychiatry and Psychology, 22* (5), 742-759.

Marshall, W.L., & Moulden, H.M. (2001). Hostility toward women and victim empathy in rapists. *Sexual Abuse: A Journal of Research and Treatment, 13*, 249-255.

Maxwell, J. A. (2005). *Qualitative research design: An interactive approach* (2nd ed.). Newbury Park, CA: Sage.

Merriam, S. B. (1998). *Qualitative research and case study applications in education* (2nd ed.). San Francisco: Jossey-Bass.

McGrath, M., Cumming, G. F., Burchard, B. L., Zeoli, S., & Ellerby, L. (2009). Current practices and emerging trends in sexual abuser management. *The Safer Society 2009 North American Survey*. Brandon, VT: The Safer Society Press.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

Nelson, M., Herlihy, B. & Oechser, J. (2002). A survey of counsellor attitudes towards sex offenders. *Journal of Mental Health Counselling, 24* (1), 1-9.

Onwuegbuzie, A.J, & Leech, N.L. (2007). An array of qualitative data analysis tools: A call for data analysis triangulation. *School Psychology Quarterly*, *22*, (4), 557–584.

Pickett, L.A. (2007). Trait versus state empathy: Evaluating the stability of empathy and the relationship between negative affect and empathy in an incarcerated sex offender population. *Dissertation Abstracts International Section A: Humanities and Social Sciences*, *68*(3-A), 5674.

Powis, B. (2002). *Offender's risk of serious harm: A literature review*. Occasional Paper number 81. Home Office: London.

Prentky, R.A. & Burgress, A.W. (2000). *Forensic management of sexual offenders*. New York. Plenum Publishers.

Salat, M. (2009). Differentiating juvenile sex offenders from juvenile non-sex offenders. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, *70* (2-B), 1356.

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health*, *18* (2), 179- 183.

Sandelowski, M. (2001). Real qualitative researchers don't count: The use of numbers in qualitative research. *Research in Nursing & Health*, *24*, 230–240.

Sandhu, DK., Rose, J., Rostill-Brookes, H.J. & Thrift, S. (2012). 'It's intense, to an extent': A qualitative study of the emotional challenges faced by staff working on a treatment programme for intellectually disabled sex offenders. *Journal of Applied Research for Intellectual Disabilities*, *25* (4), 308-318.

Serran, G. (2002). The measurement of empathy. In *In their shoes* (1st ed., pp. 16−36). Oklahoma City, OK: Wood N' Barnes.

Spencer, L. & Ritchie, J. (2012). In pursuit of quality. In *Qualitative Research Methods in Mental Health and Psycholotherapy. A guide for students and practitioners* (1st ed., pp. 227-242). Oxford: Wiley-Blackwell.

Wakeling, H.C., Webster, S.D. & Mann, R.E. (2005). Sexual offenders' treatment experience: A qualitative and quantitative investigation. *Journal of Sexual Aggression, 11* (2), 171-186.

Wastell, C.A, Cairns, D. & Haywood, H. (2009). Empathy training, sex offenders and reoffending. *Journal of Sexual Aggression, 15* (2), 149-159.

Webster, S.D., Bowers, L.E., Mann, R.E. & Marshall, W.L. (2005). Developing empathy in sexual offenders: The value of offence re-enactment. *Sexual Abuse: A Journal of Research and Treatment, 17* (1), 63-77.

Appendix A: University ethics approval letter

Psychology Research Ethics Committee

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To: **Russell Norton**
From: **Cris Burgess**
CC: **Victoria Knauer, Nicholas Moberly**
Re: **Application 2011/543 Ethics Committee**
Date: **May 3, 2013**

The School of Psychology Ethics Committee has now discussed your application, ***2011/543 – Victim Empathy work in sex offender treatment, and its impact on therapeutic alliance***. The project has been approved in principle for the duration of your study.

The agreement of the Committee is subject to your compliance with the British Psychological Society Code of Conduct and the University of Exeter procedures for data protection (http://www.ex.ac.uk/admin/academic/datapro/). In any correspondence with the Ethics Committee about this application, please quote the reference number above.

I wish you every success with your research.

Cris Burgess
Chair of Psychology Research Ethics Committee

Appendix B: National Offender Management ethics approval letter

Ministry of JUSTICE
National Offender Management Service

Mr Russell Norton
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13 March 2012

APPROVED SUBJECT TO MODIFICATION – NOMS RESEARCH – PRISONS

Dear Mr Norton

Research: Victim Empathy work in sex offender treatment, and its impact on therapeutic alliance.
Ref: 36-12

Further to your research application to the NOMS National Research Committee (NRC), and further to our letter dated 28 February 2012, the Committee is pleased to grant approval in principle for your research. Having reviewed the information that you have provided the committee has requested the following modification:

- **No incentives are to be offered to research participants, as the NRC is not persuaded that they are necessary to enable participation.**

Before the research can commence you must agree formally by email to the NRC (National.research@noms.gsi.gov.uk), confirming that you will comply with the terms and conditions outlined below and the expectations set out in the NOMS Research Instruction (http://www.justice.gov.uk/downloads/guidance/prison-probation-and-rehabilitation/psipso/psi_2010_41_research_applications.doc).

If prison establishments are to be approached as part of the research, a copy of this letter must be attached to the request to prove that the NRC has approved the study in principle.

Once the research is completed, and received by the NRC Co-ordinator, it will be lodged at the Prison Service College Library.

Yours sincerely

National Research Committee

Cc Ruth.mann@noms.gsi.gov.uk
N.J.Moberly@exeter.ac.uk
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141211

Appendix C: Participant information sheet

PARTICIPANT INFORMATION SHEET

Facilitators views on sex offender treatment

You are being invited to take part in a research study. The research will investigate facilitator's views on sex offender treatment. Taking part in this study is completely voluntary. Before you decide whether or not you would like to take part, please read this information sheet carefully. If you have any questions after reading this, please feel free to contact me (contact details are given at the end).

What is this research about?

This research is being conducted as part of the requirements of the principle investigator's Doctorate in Clinical Psychology, which is being undertaken at the University of Exeter. The research is being sponsored by the University of Exeter. The research aims to identify facilitator's views of what is important in sex offender treatment.

Who is eligible to take part?

- Anyone who has completed the advanced training in victim empathy role plays
- AND, facilitated a full Core SOTP programme in the past two years

Do I have to take part?

No, you do not have to take part. Your contribution to this research is entirely voluntary. If you do decide to take part in the study you will be given this information sheet to keep and will be asked to sign a consent form. You can contact me if you have any further questions. If you decide to take part you are still free to withdraw at any time without having to give a reason. Your data can be destroyed up until the point of anonymous transcription.

What will I have to do if I decide to take part?

The study will involve a one-to-one interview about your experiences of delivering treatment and will last approximately 45 minutes to 1 hour. This will be audio-taped and transcribed for analysis. We will also ask for the following demographic information:

- Your age, gender and professional background
- The date first trained in Core SOTP
- The number of Core SOTP groups you have facilitated
- The date end date of the last Core SOTP programme you facilitated

What will happen to the information I give?

The transcribed interviews will be analysed using qualitative content and thematic analysis. Themes from your interview will be collated with themes from other participant's interviews to give a general view of SOTP facilitator's opinions on this topic. It is these general themes that will be reported in the research write up. The anonymous transcripts may be reviewed by another coder or the research supervisors (listed below).

How will prisoner's confidentiality be maintained?

We will be asking general questions about your experiences and opinions that will not require you to provide specific details of offenders or offences; however we can appreciate that participant's may use examples to illustrate their point.
Given the nature of the analysis, specific details of offenders or offences will not be reported in the research write up. The audio-taped and transcribed information will be kept securely and offender-identifiable information will be removed in the transcription process. Once analysis is complete the audio-taped and transcribed interviews will be destroyed.

Will I have to travel far to take part?

No, the interview will be arranged at your workplace or other convenient location.

What are the possible disadvantages and risks of taking part?

Your health and wellbeing is our first priority and everything will be done to minimise any disadvantages or risks. However some people may become upset when they talk about their experiences of facilitating sex offender treatment. You don't have to discuss anything you don't want to and the interviewer will be sensitive to your feelings and concerns.
You will be asked how you are feeling at the end of the interview. If there are any difficult feelings generated through discussing your work, we would advise that you raise this in supervision with either your SOTP lead or line manager. You may also have access to a counselling service, available specifically for SOTP facilitators, which can support you. We advise this because these individuals have expertise in sex offender treatment specifically and are best placed to support you. If personal issues are raised in this research that you would rather not discuss through work support networks, we will provide contact details for support services in debriefing.
The information gathered from the interview will be kept anonymous and confidential. The only exception would be if the interview revealed a significant risk of harm to yourself or others or if an infringement of prison service rules is disclosed, in which case information may be fed back to the SOTP programme supervisor, but normally only after discussion with you. You can withdraw from the study at any time and if you would like to talk things through either during or after the study, we would be happy to arrange this.

What are the potential benefits of taking part?

We hope that the information gained in this research may provide an understanding of how facilitators view the treatment that they provide, with directions for future research and development of SOTP.

What will happen to the results of the research study?

It is hoped that the research will be published in an academic journal. Your identity will never be revealed in any report or publication. The results may be presented back to NOMS or HMPS.

Who has reviewed the research?

The research project has been reviewed and approved by the University of Exeter, School of Psychology Ethics Committee. This research has also been approved by the NOMS National Research Ethics Committee, to protect your safety, rights, wellbeing and dignity.
I will be leading the research under the supervision of Dr Vicky Knauer at Fromeside Medium Secure Unit, Bristol and Dr Nicholas Moberly at Exeter University.

What happens next?

If you would like to take part in this study, please contact us using the details below. We will then be in contact to arrange an appointment.

What if I have any questions or concerns either now or in the future?

If you have any questions or concerns please feel free to contact me:

Russell Norton
Trainee Clinical Psychologist
School of Psychology
University of Exeter
Exeter
EX4 4QG
rn235@exeter.ac.uk

Thank-you for taking the time to read this information.

Appendix D: Consent form

PSYCHOLOGY, COLLEGE OF LIFE AND ENVIRONMENTAL SCIENCES

CONSENT FORM

Title of Project: Facilitators views on sex offender treatment
Name of Researcher: Russell Norton
Please tick box

1. After reading the Study Information Sheet for the above study I agree to take part. I have had the opportunity to ask questions.
   ☐

2. I understand that my participation is voluntary and that I am free to withdraw from the study at any point, without giving a reason.
   ☐

_____	_____	
Participant name	Signature	Date of birth
_____	_____	
Researcher	Signature	Date of interview

Appendix E: Semi-structured interview schedule for facilitators

Age	Gender	Professional background
	Female Male	
Date first trained in Core SOTP	Number of Core SOTP groups	End date of last Core SOTP grp

The main research questions in bold will not asked directly, rather the semi-structured questions beneath will encourage discussion around the topic.

3. **Is victim empathy training perceived as an efficacious component of treatment by facilitators?**

- Which aspect of the programme do you feel has the biggest impact in reducing sex offenders' risk of re-offending? Why do you feel that?
- Which area of the programme do you feel has the least impact in reducing sex offenders' risk of re-offending? How come?

4. **From the facilitator perspective; does any perceived increase in the offenders' empathy for the victim strengthen the therapeutic alliance?**

- What does the 'therapeutic alliance' mean to you?
- What factors do you find help to form a good therapeutic alliance (working relationship) with participants on the programme?
- Are there any particular factors that make it harder to form a good therapeutic alliance (working relationship) with participants on the programme?

I am interested in your views on the following:

- Research with sex offenders suggests that they identify victim empathy training as one of the most important parts of the programme.

- There has been a large-scale research project which found no link between victim empathy training and reductions in re-offending rates.

Appendix F: Debrief form

Debriefing form

Thank you for taking part in this research!

If you would like any further specific information regarding this research, or if you were interested in the outcomes, please contact the researcher on the contact details provided in the participant information sheet. Unfortunately we are unable to provide specific feedback on the themes generated from your interview.
You are welcome to discuss with the researcher any difficult feelings you have had from participation in this research, together we will be able to find the right support for you.
Please see below for specific support services.
If there are any specific work concerns you are welcome to discuss your participation in this research with:

- The SOTP lead at your establishment
- Your line-manager or supervisor
- If available, the counselling service for SOTP facilitators

If there are any personal issues raised through this research, you can contact:

- Your GP, to be referred to an appropriate service
- Samaritans, Tel: 08457 909090, email: jo@samaritans.org
- MIND provides information about many topics related to mental distress. They can be contacted on 0845 766 0163

Appendix G: Code book

#	Code label	Code description
1	Active	A statement which relates to a part of the programme where group members become more active or doing something practical.
2	Appropriateness	A concept which is qualified by stating it must be "appropriate".
3	Barrier	a description of something that might get in the way of progress in therapy
4	Boring	A statement relating to a part of the programme facilitators feel is difficult to get group members to engage with on the basis that they find it less interesting.
5	Boundaries	An explicit description of the use of boundaries in the work, to provide a form of separation or space between facilitator's personal views or life and the group members.
6	Challenge - Gentle	A description of challenging within which the facilitator mediates the delivery to make it easier for the group member.
7	Challenge - Resistence	A statement about how challenges can be resisted by group members.
8	Challenge - Technique	A description of a technique for challenging group members.
9	Clinical Opinion	A description of a clinical opinion, as opposed to a research finding.
10	Collaborative	An explicit statement about collaboration, working together, alongside or other qualities that mimic this idea.
11	Consent	A statement regarding the necessity for group members consent and confidentiality to participate in the programme or exercise.
12	Decision chains	A statement relating to the Decision Chains block.
13	Denier	A description of a group member or sex offender who denies or minimises part or all of the offence.
14	Deselect	A statement where the facilitator indicates deselection from the programme could happen.
15	Deterrent	An explicit statement about deterring sex offenders from reoffending.
16	Difficult group members - Motivation	A description of the reason difficult group members may still attend the treatment group.
17	Difficult group members - Require	A description of what facilitators feel difficult group members require to transform them into motivated group members.
18	Difficult group members - Traits	A description of facilitators experiencing group members as difficult in some regard.

19	Disclosure - Difficult	A statement regarding how difficult it is to disclose something personal.
20	Disclosure - Hidden	A statement which relates to disclosing something which was previously not shared.
21	Empathy - General	A statement regarding the general quality of empathy.
22	Engagement	A statement regarding particular intellectual or cultural differences which make it harder for a group member to engage with the programme.
23	Environment - Prison	A statement relating to the impact of the prison environment to the group member, facilitator or programme.
24	Evaluation - Criticism	A statement which is critical of the system of evaluating group members progress.
25	Evaluation - Parole Board	A statement pertaining to the evaluation of the group member by the parole board.
26	Evaluation - Probation	A statement pertaining to the evaluation of the group member by probation.
27	Evaluation - Reoffending	A description of reoffending as a marker for clinical effectiveness.
28	Evaluation - Report/Review	A statement pertaining to the evaluation of the group member by report (SARN) or review.
29	Evaluation - Offenders View	A statement relating to the idea that group members are best placed to state which areas of the programme have been useful/effective for them.
30	Facilitator - Empathy	A description of the facilitator having or using empathy.
31	Facilitator - Experience - Negative	A description that relates to the greater number of programmes facilitators have facilitated having a negative effect on the process of treatment
32	Facilitator - Experience - Positive	A description that relates to the greater number of programmes facilitators have facilitated having a positive effect on the process of treatment
33	Facilitator - Motivation	A statement about the facilitators motivation to do the work.
34	Facilitator - Role	An explicit description of what facilitators see as part of their role or responsibility in their job.
35	Facilitators - Consensus	A description of the facilitator team reaching a consensus of opinion about a particular group member.
36	Facilitators - Coping	An explicit description of a method of coping for facilitators.
37	Facilitators - Damaging	A description of a way in which facilitators can impede the process of treatment or become angry with group members.
38	Facilitators - Enjoy	A description of something the facilitator is passionate about, interested in or enjoys about the work.

39	Facilitators - Skill	A statement about particular skills or techniques that facilitators use, specifically with group members.
40	Facilitators - Society	An explicit description about facilitators interactions or views in wider society.
41	Facilitators - Frustration	An explicit description of a stressor for the facilitator in the course of facilitating the programme.
42	Facilitators - Traits	A description of particular traits facilitators have or require to complete the work.
43	Feedback	An explicit statement about feedback.
44	Genuine - Dilemma	An explicit statement that it is difficult to know or test for how genuine or truthful someone might be, or a statement regarding the dilemma in being truthful.
45	Genuine - Test	An explicit statement about a particular technique for testing how genuine or truthful someone might be.
46	Genuine - Truthful	An explicit statement about being genuine or truthful.
47	Group Dynamics - Hierarchy	An explicit statement about group members creating a hierarchy based on the perceived severity of their offences.
48	Group Dynamics - Indirect	A statement regarding the indirect effects on group members of being in a group.
49	Group Dynamics - Support	A explicit statement about group members supporting one another.
50	Higher risk	A factor which is related to or contributes to a greater risk of reoffending.
51	Individualised	A description of valuing or interacting with group members in non-standard ways (Being human).
52	Insight	A statement relating to group members developing insights into their offending and learning from the process. Clustered as different to understanding risk.
53	Lower risk	A factor which is related to or contributes to a lesser risk of reoffending.
54	LRES	A statement relating to the LRES block.
55	Memory - Emotion	A statement linking an experience which elicits emotion to later memory recall.
56	Mistrust	A description of group members mistrusting the facilitator, programme or process.
57	Motivated group members - Traits	A description of a group member who is motivated to address their offending behaviour in treatment.
58	New experience	A statement which includes the caveat that the experience is new for the group member.
59	New Me (Future Me)	A statement relating to the New Me (Future Me) Block, which focusses on role plays and other exercises to put understanding and old me, to design strategies for future management of risk.

60	Not Punishing	A statement within which the facilitator indicates the practice, exercise or programme is not or should not be punishing.
61	Programme - Caveat	A statement that provides a caveat for the effectiveness of the programme, explicitly stating if certain conditions are met then effectiveness will increase.
62	Programme - Deficits	A statement containing an appraisal of the deficits of the programme.
63	Programme - Development	A description relating to the future development of the programme.
64	Programme - Strengths	A statement containing an appraisal of strengths of the programme, its exercises and structure.
65	Programme - Structure	A description of the programmes structure.
66	Programme - Timing	A statement relating to the timing of the programme in the group members sentence.
67	Programme -Aim	A statement of what the facilitator feels is the aim of the treatment programme.
68	Progress - Definition	A statement in which the facilitator attempts to define progress on the programme.
69	Progress - Evidenced by	A statement of how progress in treatment can be evidenced.
70	Progress - Implications	A statement regarding the implications of not demonstrating progress on the programme
71	Progress - Lack	A statement that indicates the group member is not making progress.
72	Punishing	A description of how the programme can be punishing.
73	Relationships	A statement about the group members relationships.
74	Research - Methodological problems	A description of the methodological problems with a particular piece of research.
75	Research - Reaction	A statement containing the facilitators personal feelings towards the piece of research.
76	Research - Trust	A statement relating to the facilitator trusting research as a form of evidence.
77	Risk management	A statement relating to the management of risk of reoffending.
78	Role play - Caveat	A description of particular conditions that need to satisfied to increase the effectiveness of role plays generally.
79	Role play - Intervention	A description of a general role play intervention.
80	Role play - Utility	A description of how role play generally can be useful.
81	Sex offence - Chain	A statement where the sex offence is seen as a chain of events rather than a discrete event.

82	Sex offence - Coping	A description of the sex offence which takes into consideration the offenders coping style.
83	Sex offence - Description	A statement within which the facilitator describes a sexual offence.
84	Sex offence - Explanation	A statement where the facilitator considers the explanation for why sex offenders offend or achieving an unmet need.
85	Sex offender - Linking	A statement about how past experience influences offenders future behaviour.
86	Sex offenders - Cure	A statement that relates to the concept of sex offenders wanting or needing to be "cured", or statement about how they cannot be "cured".
87	Sex offenders - Defence	A description of a particular psychological strategy or defence in order to avoid painful feelings about the offence.
88	Sex offenders - Historical	A statement regarding the historical context of the sex offender or sex offence.
89	Sex offenders - Motivation	A statement regarding the sex offenders motivation to engage with the programme.
90	Sex offenders - Sexual interests	A statement regarding the sexual offenders sexual interests.
91	Sex offenders - Traits	A statement regarding the general traits of sexual offenders.
92	Sex offenders - Vulnerable	A statement about sex offenders being vulnerable.
93	Sexual interest in children	An explicit statement about sexual interests in children.
94	Shame	A statement within which the facilitator describes shame.
95	Superficial Compliance	A description of group members engaging on a superficial level (telling facilitators what they want to hear).
96	Supervision	An explicit statement about the use of supervision or other suitable monitoring of practice, for example counselling. Including discussion or work with co-facilitator or period of reflection, for facilitators to improve their practice.
97	Therapeutic relationship - Aim	A statement about the aim or point of developing the therapeutic relationship.
98	Therapeutic relationship - Challenges	A statement about particular factors which may threaten the integrity of the therapeutic relationship.
99	Therapeutic relationship - Easier	A statement about what makes it easier to form a therapeutic relationship.
100	Therapeutic relationship - Is not	A description which the facilitator qualifies by stating this is not an example of therapeutic practice.

101	Therapeutic relationship - Quality	A description of particular qualities or sense which makes the relationship therapeutic.
102	Threat	A description of something that is threatening to group members.
103	Timing	A statement relating to the importance of timing within the intervention. See Programme - Timing code for timing of programme within the sentence.
104	Transparency	A statement that relates to the concept of being explicit when communicating.
105	Traumatising	A statement which contains the understanding that the exercise or part of the programme is traumatising.
106	Understanding risk	A statement relating to the importance of understanding the factors which may predict future sex offending.
107	Victim empathy - Caveat	A statement about specific conditions that would need to be met to either increase the effectiveness of the victim empathy role play exercise or the influence of the concept of victim empathy in reducing reoffending. For example a limitation of victim empathy.
108	Victim empathy - Concept	A statement relating to the concept of someone empathising with the thoughts, feelings and behaviour of the victim of a sexual offence.
109	Victim empathy - Emotional	A statement relating to the concept of the victim empathy role plays or actual experience of empathising with a victim as an experience which elicits a high amount of emotion, or effects someone at an emotional level.
110	Victim empathy - Damage	An explicit description of the victim empathy role play exercises having a detrimental effect on group members.
111	Victim empathy - Indirect	A statement regarding the indirect effects of the victim empathy role plays, outside of achieving a specific aim on the programme. For example, statements that relate to it making a big impression, but not necessarily achieving a specific aim.
112	Victim empathy - Intervention	A specific description of the victim empathy role play exercises.
113	Victim empathy - Useful	A statement describing the victim empathy role play exercises as useful in achieving a specific aim on the programme.
114	Planning	A statement relating to planning exercises within the programme.
115	Practice	A statement relating to the opportunity to practice new skills.
116	Consistency	A statement relating to being consistent across time and context.

117	Modelling	A statement relating to using another person as an example to follow.
118	Judging	A statement relating to judging in a way that is deterimental to the individual being judged. For example, not a fair assessment.
119	Expectation	A statement about of set of expectations regarding conduct, behaviour or engagement.
120	Disgust	A description of a negative emotional reaction to a particular stimulus.
121	Warmth	A description of communicating a positive emotional outlook, not related to temperature.
122	Acceptance	A statement relating to unconditional positive regard for another person.
123	Strategies - Social Skills	A description of a strategy focussed on in the programme.
124	Strategies - Problem solving	A description of a strategy focussed on in the programme.
125	Strategies - Coping skills	A description of a strategy focussed on in the programme.
126	Strategies - Perspective taking	A description of a strategy focussed on in the programme.
127	Draining	A statement pertaining to an emotional reaction to either another person or the programme or exercise generally.
128	Avoidant	A statement which describes someone trying to avoid a specific task, intellectual or emotional exploration.
129	Aggressive	A statement that relates to be undermining of the other person, or actually physically aggressive.
130	Responsible	A statement that describes someone taking responsibility for their actions, thoughts or others expectations of them.
131	Unrealistic	A statement pertaining to the generalisability or usefulness of exercises and goals.
132	Inadequate	A description of the emotioanl self-appraisal, which could also encompass poor self-esteem.
133	Manipulative	A description of someone who uses deception with others to achieve their goals.
134	Fearful	A statement containing a fear response.
135	Victimised	A statement relating to the assessment of self as a victim. For example to feel sorry for ones self.
136	Blaming	A statement within which the person blames an other or circumstances rather than looking for self-responsibility.
137	Naive	A statement relating to making assumptions or predictions without the benefit for further experience or practice.

138	Cognitive distortion	A statement which relates to the practice of manipulating thought processes in order to think about the situation in a more personally favourable way.
139	Active listening	A statement containing the specific skill of active listening.
140	Slowly	A statement which is qualified by the necessity to conduct the exercise or part of the programme slowly, rather than rushing.
141	Humour	A statement which relates to the use of humour.
142	Non-verbal	A statement relating to non-verbal communication. This includes body language, tone of voice, eye contact etc.
143	Open question	A statement relating to a question with no specific options to answer with, requiring an original response.
144	Summarising	A statement relating to the particular technique of summarising what someone has said and repeating it back to them for clarification.
145	Safe	A statement which relates to the perceived security with which someone could talk openly and have a feeling of being safe in doing so.
146	Trust	A statement which relates to the emotional experience of trust.
147	Treatment effect	A statement qualifying the possible impact the effect treatment will have.
148	Unique	A description within which a quality of the exercise is unique.
149	Empathy - Deficit	A description regarding a specific lack of empathy in group members or sex offenders generally. This may also related to victim-specific empathy.
150	Strategies - General	A description of non-specific strategies that group members may be encouraged to develop or use whilst on the programme.
151	Ineffective	A description of the impact of a paticular exercise, intervention or programme, in meeting particular aims, for example, reducing re-offending.

Appendix H: Frequency of use for all codes

Number of sources codes used in	Number of times code is used	Code
12	59	Victim empathy - Caveat
	54	Individualised
	45	Difficult group members - Traits
	41	Facilitator - Enjoy
	34	Insight
	33	Victim empathy - Indirect
	28	Therapeutic relationship - Quality
	27	Victim empathy - Intervention
11	35	Facilitator - Empathy
	35	Facilitator - Frustration
	29	Evaluation - Offenders View
	29	Facilitator - Role
	26	Collaborative
	22	Decision chains
10	37	Superficial Compliance
	35	Progress - Evidenced by
	30	Motivated group members - Traits
	30	Risk management
	25	Supervision
	24	Genuine - Truthful
	21	Evaluation - Report/Review
	17	Group Dynamics - Support
	17	New Me (Future Me)
	14	Victim empathy - Emotional
9	28	Disclosure - Hidden
	25	Challenge - Technique
	23	Genuine - Test
	22	Victim empathy - Useful
	21	Not Punishing
	20	Boundaries
	20	Consistency
	17	Disclosure - Difficult
	17	Unique
	14	Genuine - Dilemma
8	41	Understanding risk
	25	Boring
	24	Facilitator - Experience - Positive
	23	Responsible
	21	Programme - Development

	19	Safe
	18	Facilitator - Coping
	18	Facilitator - Damaging
	18	Shame
	18	Transparency
	17	Denier
	17	New experience
	15	Challenge - Gentle
	13	Programme - Structure
	13	Sexual interest in children
	12	Relationships
	10	Challenge - Resistance
	10	Fearful
7	14	Difficult group members - Require
7	15	Facilitator – Skill
7	17	Facilitator – Society
7	16	Group Dynamics - Indirect
7	10	Practice
7	11	Programme - Deficits
7	17	Research - Methodological problems
7	17	Research - Reaction
7	11	Sex offence - Explanation
7	9	Sex offender - Linking
7	11	Sex offenders - Historical
7	9	Timing
7	10	Victim empathy - Damage
6	18	Active
6	10	Deselect
6	12	Facilitator - Motivation
6	9	Humour
6	12	Inadequate
6	8	Mistrust
6	6	Planning
6	7	Programme – Aim
6	7	Slowly
6	11	Strategies - General
6	10	Therapeutic relationship - Challenges
6	11	Traumatising
6	12	Victim empathy - Concept
5	17	Cognitive distortion
5	5	Consent
5	8	Disgust
5	8	Empathy – Deficit
5	13	Environment - Prison
5	9	Evaluation - Parole Board

5	8	LRAES
5	8	Memory – Emotion
5	5	Modelling
5	6	Non-verbal
5	6	Programme - Timing
5	9	Sex offence – Chain
5	7	Sex offenders - Cure
5	7	Sex offenders - Motivation
5	12	Sex offenders - Traits
5	7	Therapeutic relationship - Aim
5	7	Therapeutic relationship - Easier
5	6	Therapeutic relationship - Is not
5	6	Unrealistic
5	10	Victimised
5	8	Warmth
4	5	Barrier
4	6	Difficult group members - Motivation
4	5	Empathy – General
4	11	Expectation
4	7	Programme - Strengths
4	4	Progress – Lack
4	5	Sex offenders - Sexual interests
3	6	Active listening
3	3	Deterrent
3	4	Evaluation - Reoffending
3	4	Facilitator - Experience - Negative
3	6	Facilitator – Traits
3	10	Naive
3	3	Open question
3	5	Programme - Caveat
3	3	Progress - Implications
3	5	Punishing
3	4	Role play – Caveat
3	4	Role play - Intervention
3	4	Role play – Utility
3	3	Sex offence - Description
3	4	Strategies - Perspective taking
2	3	Aggressive
2	2	Avoidant
2	6	Clinical Opinion
2	2	Draining
2	3	Evaluation - Probation
2	3	Facilitator - Consensus
2	2	Group Dynamics - Hierarchy
2	2	Ineffective

2	2	Manipulative
2	6	Research – Trust
2	3	Sex offence - Coping
2	3	Sex offenders - Defence
2	2	Summarising
1	1	Acceptance
1	2	Appropriateness
1	1	Blaming
1	2	Feedback
1	1	Judging
1	3	Progress - Definition
1	1	Sex offenders - Vulnerable
1	2	Strategies - Problem solving
1	1	Strategies - Social Skills
1	1	Threat
1	1	Trust
0	0	Engagement
0	0	Evaluation - Criticism
0	0	Higher risk
0	0	Lower risk
0	0	Strategies - Coping skills
0	0	Treatment effect